Instructions for Completion of E-Medicaid Application

This form is to enable persons from Alabama, Louisiana and Mississippi who are in Virginia as a result of being displaced by Hurricane Katrina to apply for medical assistance. This form collects the only information needed to enroll individuals in E-Medicaid. There are no income or resource requirements for this program and no verification is required.

Step 1. Complete E-Medicaid application. Completed forms may be submitted to an authorized outstation site or a local department of social services. The information on your application will be used to enroll you in the E-Medicaid program.

Step 2. Once enrolled in E-Medicaid, you will be given an E-Medicaid Eligibility Certification form that contains the E-Medicaid Identification Numbers. This form allows you to access needed medical services and must be shown when you receive a medical service. Only the individuals listed on this form are authorized to receive services through the E-Medicaid program. The certification form must not be shared or photocopied.

If the certification form is lost, please contact the local department of social services to request a replacement.

To ensure continued access to medical care, please report all changes of address to the local department of social services in the area where you live.

Commonwealth of Virginia
Emergency Medical Assistance Application (E-Medicaid)

For Official Use Only
DATE RECEIVED _____

FIPS _____ **AID CATEGORY 919**

List the names of the persons in your family applying for Emergency Medical Assistance

Name	Date of Birth	Social Security Number (If Known)	Race	Sex	Have Medicaid/SCHIP in Previous State
1.					□ No □ Yes If yes, State _____
2.					□ No □ Yes If yes, State _____
3.					□ No □ Yes If yes, State _____
4.					□ No □ Yes If yes, State _____
5.					□ No □ Yes If yes, State _____

Current Address in Virginia: _____ **Phone Number:**_____

City:_____ **State:VA** **Zip Code:**_____

Address prior to Hurricane Katrina:_____

City/County/Parish:_____**State:** _____**Zip Code:** _____

I declare that the above named persons were displaced by Hurricane Katrina and are applying for Emergency Medical Assistance in Virginia. By signing my name below, I certify that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that anyone who gives false information or receives benefits for which he is not eligible, can be prosecuted for perjury, larceny and/or fraud.

Signature: _____**Date:** _____